U.S. Department of Labor

Office of Administrative Law Judges
36 E. 7th St., Suite 2525
Cincinnati, Ohio 45202

(513) 684-3252
(513) 684-6108 (FAX)

Issue Date: 19 December 2005

Case No. 2004-BLA-5186

In the Matter of:
CARMEL AKERS
Claimant,

v.

CORBIN COAL CO., INC.,
Employer,
and
KY COAL PRODUCERS SELF-INSURED FUND,
c/o ALTERNATIVE SERVICES CONCEPT
Carrier,

and
DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Party-in-Interest.

APPEARANCES:
Stephen A. Sanders, Esq.
On behalf of the Claimant

David H. Neeley, Esq.
On behalf of the Employer

BEFORE: THOMAS F. PHALEN, JR.
Administrative Law Judge

DECISION AND ORDER – DENIAL OF BENEFITS

This is a decision and order arising out of a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1977, 30 U.S.C. §§ 901-962, ("the Act") and the regulations thereunder, located in Title 20 of the Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title.[1]

[1] The Department of Labor amended the regulations implementing the Federal Coal Mine Health and Safety Act of 1969, as amended. These regulations became effective on January 19, 2001, and are found at 65 Fed. Reg. 80, 045-80,107 (2000)(to be codified at 20 C.F.R. Parts 718, 722, 725 and 726). On August 9, 2001, the United States District Court for the District of Columbia issued a Memorandum and Order upholding the validity of the new regulations. All citations to the regulations, unless otherwise noted, refer to the amended regulations.

On November 6, 2003, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs, for a hearing. (DX 45).[2] A formal hearing on this matter was conducted on February 2, 2005, in Pikeville, Kentucky by the undersigned Administrative Law Judge. All parties were afforded the opportunity to call and to examine and cross examine witnesses, and to present evidence, as provided in the Act and the above referenced regulations.

ISSUES[3]

The issues in this case are:

1. Whether the claim was timely filed;

2. Whether the Miner has pneumoconiosis as defined by the Act;

3. Whether the Miner's pneumoconiosis arose out of coal mine employment;

4. Whether the Miner is totally disabled; and

5. Whether the Miner's disability is due to pneumoconiosis.

(DX 45).

Based upon a thorough analysis of the entire record in this case, with due consideration accorded to the arguments of the parties, applicable statutory provisions, regulations, and relevant case law, I hereby make the following:

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background

Carmel Akers ("Claimant") was born on October 23, 1932; he was 72 years old at the time of the hearing. (Tr. 14). He completed the fifth grade. On November 1, 1957, Claimant married Nancy Ellen Edmonds, and they remain married. (DX 2, 9). On his application, Claimant also noted that he was previously married, but provided no details about dependency or

[2] In this Decision, "DX" refers to the Director's Exhibits, "EX" refers to the Employer's Exhibits, "CX" refers to the Claimant's Exhibits, and "Tr." refers to the official transcript of this proceeding.

[3] At the hearing, Employer withdrew the following issues: whether the person whose disability the claim is based is a miner; whether the miner worked as a miner after December 31, 1969; whether the claimant has one dependent for purpose of augmentation; whether the named employer is the responsible operator; and whether the miner's most recent period of cumulative employment of not less than one year was with the named responsible operator. (Tr. 11-12). The parties stipulated to at least 20 years of coal mine employment. (Tr. 11). In addition, while Employer contends that this is a subsequent claim requiring proof of a material change in conditions per §725.309(d), there is no evidence in the record of a prior claim. Therefore, I find that this is an initial claim. Finally, Employer preserves other issues for appeal purposes that will not be addressed by the undersigned. (DX 45, Item 16-18; Tr. 12).

substantial contributions. (DX 2). Claimant does not have any dependent children. (DX 2). I find that Claimant has one dependent for purposes of augmentation.

On his application for benefits, Claimant stated that he engaged in coal mine employment for 29 ½ years. (DX 2). Claimant's last coal mine employment was as a rock truck, dozer, and high lift operator, but he also stated that he swept and shot coal and operated an auger. (Tr. 14-19; DX 3-4). Claimant described the physical requirements of the work to include sitting for six hours per day, standing for four hours per day, and lifting and carrying 20 lbs a distance of 20 feet two times per day. (DX 4). At the hearing, Claimant added that he was also required to lift and carry big jacks, auger bits, and multiple 25 lb bags on a daily basis, and that getting into the heavy equipment required a substantial climb. (Tr. 15-16, 20). Claimant stated that he last worked in and around coal mines in 1987, but quit due to breathing problems. (Tr. 14; DX 2). On his application, Claimant noted that he previously filed a federal Black Lung Claim, but it was denied. (DX 2).

Procedural History

Claimant filed a claim for benefits under the Act on August 31, 2001. (DX 2). On August 4, 2003, the District Director, Office of Workers' Compensation, issued a proposed decision and order awarding benefits. (DX 35). On August 11, 2003, Employer requested a formal hearing. (DX 36). On November 6, 2003, this matter was transferred to the Office of Administrative Law Judges. (DX 45).

Claimant noted in his application that his previous claim for benefits was denied. (DX 2). Employer continues to contest the subsequent claim issue. (Tr. 12). The Director's proposed decision and order states that this is a refilled claim rather than a modification request because more than one year elapsed between the prior denial and the filing of this claim, and thus, the provisions of §725.309(d) are applicable. (DX 35). Despite these inferences that this is a subsequent claim, a review of the record reveals that Mr. Akers' previous claim is not part of the record in the instant action.

The undersigned contacted the Director's office on February 9, 2005, and was informed that it had approved withdrawal of Mr. Akers' prior claim on August 28, 2001 under the provisions of §725.306. As a result, the Director considered the prior claim not to have been filed, and thus, it was without jurisdiction to forward any part of the claim to the undersigned. Since Claimant's previous claim is not available to the undersigned, I am not able to treat this matter as a subsequent claim under §725.309(d). Also, I do not have access to the Director's 2001 approval of withdrawal so I am unable to definitively determine whether this is an initial or subsequent claim. Therefore, even though statements in the record indicate that this is a subsequent claim, without additional evidence it is only possible for the undersigned to treat the instant action as an initial claim for benefits under the Act.[4]

[4] All indications from the claim file lead the undersigned to believe that this is a subsequent claim and not an initial claim for benefits under the Act. In fact, when I first looked at the file I assumed that Director had simply failed to forward the entire case file to the Office of Administrative Law Judges. Only through discussions with the Director's office was I able to glean a true accounting of how this case came to be before me as an initial claim.

Timeliness

Under § 725.308(a), a claim of a living miner is timely filed if it is filed "within three years after a medical determination of total disability due to pneumoconiosis" has been communicated to the miner. Section 725.308(c) creates a rebuttable presumption that every claim for benefits is timely filed. This statute of limitations does not begin to run until a miner is actually diagnosed by a doctor, regardless of whether the miner believes he has the disease earlier. *Tennessee Consolidated Coal Company v. Kirk*, 264 F.3d 602 (6th Cir. 2001). In addition, the court stated:

> The three-year limitations clock begins to tick the first time that a miner is told by a physician that he is totally disabled by pneumoconiosis. This clock is not stopped by the resolution of a miner's claim or claims, and, pursuant to *Sharondale*, the clock may only be turned back if the miner returns to the mines after a denial of benefits. There is thus a distinction between premature claims that are unsupported by a medical determination, like Kirk's 1979, 1985, and 1988 claims, and those claims that come with or acquire such support. Medically supported claims, even if ultimately deemed "premature" because the weight of the evidence does not support the elements of the miner's claim, are effective to begin the statutory period. [Footnote omitted.] Three years after such a determination, a miner who has not subsequently worked in the mines will be unable to file any further claims against his employer, although, of course, he may continue to pursue pending claims.

Id.

Failure to include any reference to the previous claim upon approved withdrawal presents three significant issues for this office. First, based solely on the case file, it is impossible to determine whether claims like the instant action are initial or subsequent claims. This places the administrative law judge in the unenviable position of either guessing at the procedural posture, or ordering the Director to supply the complete file so that proper handling can be insured. This problem is only exacerbated when the Director erroneously bases the proposed decision and order on a subsequent claim analysis.

Second, when an administrative law judge is denied access to the prior case file, it is not possible for him to thoroughly adjudicate whether a claim is a subsequent or initial filing. I note, however, that it is not for the hearing judge to order production of a withdrawn claim file absent an appropriate party motion arguing good cause. Thus, in the instant claim, since the Employer failed to file a motion requesting production of the prior claim, absent a *sua sponte* order, I am unable to determine whether the prior withdrawal was appropriate or whether this is a subsequent or initial claim.

Third, without the evidence from the prior claim, it is typically not possible for an administrative law judge to determine whether previous opinions finding a claimant totally disabled due to pneumoconiosis were reasoned, and thus, whether the claim was timely filed. In addition, since §725.306 (b) requires a properly withdrawn claim to be considered not to have been filed, even if the prior record is supplied and includes a reasoned opinion finding total disability to pneumoconiosis, an administrative law judge is arguable not permitted to look to any of the evidence to make a determination of whether the later claim is timely. Again, since the Employer in the instant action failed to move the undersigned to procure the prior claim file, it is not necessary at this juncture to make a determination as to how such a situation should be resolved.

In an unpublished opinion arising in the Sixth Circuit, *Furgerson v. Jericol Mining, Inc.*, BRB Nos. 03-0798 BLA and 03-0798 BLA-A (Sept. 20, 2004) (unpub.), the Benefits Review Board held that *Kirk*, 264 F.3d 602 is controlling and directed the administrative law judge in that case to "determine if [the physician] rendered a well-reasoned diagnosis of total disability due to pneumoconiosis such that his report constitutes a 'medical determination of total disability due to pneumoconiosis which has been communicated to the miner'" under § 725.308 of the regulations.

Considering the facts of the instant claim, Claimant testified that both Drs. Mann and Huddle had previously told him that he was totally disabled due to Black Lung disease. (Tr. 26, 30). Claimant also confirmed that Dr. Mann would have told him of this total disability in 1987, "when he last worked," or before. (Tr. 27). Finally, Claimant did not think Dr. William Clark had ever told him he was totally disabled due to pneumoconiosis. (Tr. 27).

The hearing testimony establishes that a diagnosis of total disability due to pneumoconiosis was clearly communicated to Claimant on several occasions. The conflict with the regulations, however, arises when trying to prove a medical diagnosis of total disability due to pneumoconiosis within three years of filing the instant claim.

The alleged 1987 diagnosis of total disability due to pneumoconiosis by Dr. Mann would fall 14 years prior to the instant claim, and thus would violate the regulatory requirements. But there are several problems with this diagnosis. First, there is no evidence in the record concerning a 1987 evaluation by Dr. Mann. Looking to *Furgerson* for guidance, the Board held that I must determine if the physician who communicated total disability due to pneumoconiosis to the miner rendered a well-reasoned diagnosis. Without access to Dr. Mann's report, this is not possible. Second, while the record from the previous claim may include diagnoses of total disability due to pneumoconiosis, due to Claimant's approved withdrawal of the prior claim, I do not have access to the evidence included in that claim, and even if I did, I am not permitted to review those opinions to determine their reasonableness. Third, even if I were able to review Dr. Mann's 1987 diagnosis, there is some question as to whether Claimant's 1987 employment would invalidate the running of the statue of limitations.

Despite Claimant's testimony that a diagnosis of total disability was communicated to him more than three years prior to the filing of the instant claim, I find this claim is timely. I reach this conclusion after considering the evidentiary deficiencies outlined above in the framework of subsection 308(c)'s statutory presumption of timeliness. I find that the Employer has failed to rebut this presumption, and therefore, this claim will not be dismissed on the basis of timeliness.

Length of Coal Mine Employment

Claimant was a coal miner within the meaning of § 402 (d) of the Act and § 725.202 of the regulations. Based on Social Security Earnings records, the Director found 29 years of coal mine employment. (DX 35). The parties, however, have stipulated to at least 20 years of coal mine employment (Tr. 11). A review of the record supports this stipulation. (DX 5-8)).

Therefore, I find that Claimant engaged in qualifying coal mine employment for at least 20 years.

Claimant's last employment was in the State of Kentucky; (DX 16), therefore, the law of the Sixth Circuit is controlling. [5]

Responsible Operator

Liability under the Act is assessed against the most recent operator which meets the requirements of §§ 725.494 and 725.495. The District Director identified Corbin Coal Co. as the putative responsible operator because it was the last operator to employ Claimant for one full year. (DX 16). Corbin Coal Co., Inc. does not contest this issue. (Tr. 11-12). Therefore, after review of the record, I find that Corbin Coal Co., Inc. is properly designated as the responsible operator in this case.

MEDICAL EVIDENCE

Section 718.101(b) requires any clinical test or examination to be in substantial compliance with the applicable standard in order to constitute evidence of the fact for which it is proffered. *See* §§ 718.102 - 718.107. The claimant and responsible operator are entitled to submit, in support of their affirmative cases, no more than two chest x-ray interpretations, the results of no more than two pulmonary function tests, the results of no more than two blood gas studies, no more than one report of each biopsy, and no more than two medical reports. §§ 725.414(a)(2)(i) and (3)(i). Any chest x-ray interpretations, pulmonary function studies, blood gas studies, biopsy report, and physician's opinions that appear in a medical report must each be admissible under § 725.414(a)(2)(i) and (3)(i) or § 725.414(a)(4). §§ 725.414(a)(2)(i) and (3)(i). Each party shall also be entitled to submit, in rebuttal of the case presented by the opposing party, no more than one physician's interpretation of each chest x-ray, pulmonary function test, arterial blood gas study, or biopsy submitted, as appropriate, under paragraphs (a)(2)(i), (a)(3)(i), or (a)(3)(iii). §§ 725.414(a)(2)(ii), (a)(3)(ii), and (a)(3)(iii). Notwithstanding the limitations of §§ 725.414(a)(2) or (a)(3), any record of a miner's hospitalization for a respiratory or pulmonary or related disease, or medical treatment for a respiratory or pulmonary or related disease, may be received into evidence. § 725.414(a)(4). The results of the complete pulmonary examination shall not be counted as evidence submitted by the miner under § 725.414. § 725.406(b).

Claimant selected Dr. Imtiaz Hussain to provide his Department of Labor sponsored complete pulmonary examination. (DX 10). Dr. Hussain conducted the examination on June 26, 2002. (DX 11). He also conducted a follow-up ABG study on October 23, 2002. I admit Dr. Hussain's reports under § 725.406(b). I also admit Dr. Barrett's quality-only interpretation of the chest x-ray under § 725.406(c).

Claimant completed a Black Lung Benefits Act Evidence Summary Form. (CX 6). In addition to the DOL sponsored evaluation, Claimant designated Dr. Baker's September 28, 2002

[5] Appellate jurisdiction with a federal circuit court of appeals lies in the circuit where the miner last engaged in coal mine employment, regardless of the location of the responsible operator. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200 (1989)(en banc).

complete pulmonary evaluation. Claimant also designated Dr. Cappiello's interpretation of the December 27, 2004 film as initial evidence, and Dr. Ahmed's interpretations of the February 22, 2002 and June 26, 2002 films as rebuttal evidence. Next, Claimant designated Dr. Ebeo's December 27, 2004 PFT as initial evidence, and Dr. Cohen's January 11, 2005 report as rebuttal of Dr. Fino's February 22, 2002 PFT. Next, Claimant designated Dr. Cohen's January 11, 2005 report as rebuttal of Dr. Fino's February 22, 2002 ABG and Dr. Hussain's October 23, 2002 and June 26, 2002 ABGs. Finally, Claimant designated Dr. Mann's January 6, 2003 report as a narrative medical opinion. Claimant's evidence complies with the requisite quality standards of §§ 718.102-107 and the limitations of § 725.414 (a)(3). Therefore, I admit this evidence.

Employer completed a Black Lung Benefits Act Evidence Summary Form. (EX 3). In addition to the DOL sponsored evaluation, Employer designated Dr. Halbert's reading of the August 29, 1997 chest x-ray and Dr. Fino's reading of the February 22, 2002 film as initial evidence, and Dr. Halbert's readings of the September 28, 2002 and June 26, 2002 films as rebuttal evidence. Employer next designated Dr. Fino's February 22, 2002 PFT and ABG as initial evidence, and Dr. Westerfield's November 26, 2002 report as rebuttal of the October 23, 2002 ABG. Employer also designated Dr. Broudy's August 15, 2003 medical report. Employer's evidence complies with the requisite quality standards of §§ 718.102-107 and the limitations of § 725.414(a)(3). Therefore, I admit the evidence Employer designated in its summary form.

At the hearing, Employer submitted supporting depositions for Drs. Halbert and Broudy. The provisions at § 725.414(c) provide that "[a] physician who prepared a medical report admitted under this section may testify with respect to the claim . . . by deposition." Therefore, I find Dr. Broudy's supporting deposition is admissible. Concerning Dr. Halbert's deposition, however, Claimant objected to admission on the grounds that his testimony was limited to x-ray readings. (Tr. 10). In *Tapley v. Bethenergy Mines, Inc.*, BRB No. 04-0790 BLA (May 26, 2005) (unpub.), the Board affirmed the administrative law judge's exclusion of deposition testimony because the physician offered only chest x-ray interpretations and did not provide a medical opinion. Adopting the *Tapley* reasoning, I find that Dr. Halbert's deposition is not admissible.

X-RAYS

Exhibit	Date of X-ray	Date of Reading	Physician / Credentials	Interpretation
DX 14	8/29/97	7/9/02	Halbert, BCR[6], B-reader[7]	Negative

[6] A physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Association. *See* 20 C.F.R. § 727.206(b)(2)(III). The qualifications of physicians are a matter of public record at the National Institute of Occupational Safety and Health reviewing facility at Morgantown, West Virginia.

[7] A "B" reader is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successful completion of an examination conducted by or on behalf of the Department of Health and Human Services. This is a matter of public record at HHS National Institute for Occupational Safety and Health reviewing facility at Morgantown, West Virginia. (42 C.F.R. § 37.5l) Consequently, greater weight is given to a diagnosis by a "B" Reader. *See Blackburn v. Director, OWCP*, 2 B.L.R. 1-153 (1979). Dr. Baker's x-ray report noted that he was not a B-reader, but the June 7, 2004 "B-reader" list states that he was a B-reader from February 1, 1993 to January 31, 2001, and again from June 1, 2002 to present.

DX 13	02/22/02	5/31/02	Fino, B-reader	Negative
DX 31	02/22/02	12/3/02	Ahmed, BCR, B-reader	2/1ts
DX 11	06/26/02	6/26/02	Hussain	2/1 tq
DX 12	06/26/02	8/11/02	Barrett, BCR, B-reader	Quality only
DX 28	06/26/02	10/9/02	Halbert, BCR, B-reader	Negative
DX 31	06/26/02	12/3/02	Ahmed, BCR, B-reader	1/1 ts
DX 32	09/28/02	9/28/02	Baker, B-reader	1/1 tp
EX 2	09/28/02	8/26/03	Halbert, BCR, B-reader	1/1 st[8]
CX 1	12/27/04	1/05/05	Cappiello, BCR, B-reader	2/2 pt

PULMONARY FUNCTION TESTS

Exhibit/ Date	**Co-op./ Undst./ Tracings**	**Age/ Height[9]**	**FEV_1**	**FVC**	**MVV**	**FEV_1/ FVC**	**Qualifying Results**
DX 13 2/22/02	Not listed/ Not listed/ Yes	69 69”	2.56	3.28	----	78	No/invalid[10]
DX 11 6/26/02	Poor/ Poor/ Yes	69 72”	2.58 2.28*	3.88 3.23*	61	66.5 70.6*	No No*
DX 32 9/28/02	Not listed/ Not listed/ Yes	69 70”	2.33 2.36*	3.65 3.54*		64 67*	No[11] No*
CX 3 12/27/04	Good/ Good/ Yes	72 72”	2.29	3.01	44	76	No[12]

* indicated post-bronchodilator values

[8] Dr. Halbert stated that this film demonstrated findings which are seen in some types of pneumoconiosis, but he emphasized that these are not consistent with those seen in CWP.

[9] The factfinder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). Claimant testified that he is about six feet tall. (Tr. 26). Since this testimony supports two the recorded height in two of the four PFTs, I find Claimant’s height to be 72 inches.

[10] Dr. Robert Cohen, an internist, pulmonologist, and B-reader, stated that the tracings showed very poor effort with multiple starts and stops of exhalation and variable effort. (CX 4). Also, he stated that the tracings reflecting the slow vital capacity, lung volume measurements, and diffusion show tests which were well performed and interpretable. In conclusion, Dr. Cohen opined that the February 22, 2002 spiromentry was completely uninterpretable and gave no indication whatsoever of Claimant’s pulmonary capacity.

[11] Dr, Broudy noted that the tracings suggest that effort was less than optimal, but the results still easily exceed the minimum federal criteria for disability in coal workers. (EX 1).

[12] While Dr. Ebeo interpreted these values to reveal mild to moderate restrictive and obstructive airway disease, and a severe impairment based on diffusion lung capacity, since only the PFT was designated, I may not consider his interpretation of the results.

ARTERIAL BLOOD GAS STUDIES

Exhibit	**Date**	**pCO_2**	**pO_2**	**Qualifying**
DX 13	02/22/02	35.1	71.1	No[13]
DX 11	06/26/02	37.1 30*	71 90*	No No/invalid[14]
DX 32	09/28/02	35	85	No
DX 29	10/23/02	36 28*	72 119*	No No/invalid[15]

* indicates post-exercise values

Narrative Reports[16]

Dr. Imtiaz Hussain examined the Claimant on June 26, 2002. (DX 11). Dr. Hussain considered the following: symptomatology (sputum, wheezing, dyspnea, and cough), employment history (30 years coal mine employment), individual history (frequent colds, attacks of wheezing, and arthritis), family history (diabetes, cancer, and stroke), smoking history (40 years at one pack per day, quitting in 1987), physical examination (bilateral rhonchi), chest x-ray (2/1), PFT (poor effort), ABG (normal), and an EKG (normal). Dr. Hussain diagnosed pneumoconiosis and COPD caused by coal dust exposure and tobacco abuse. He explicitly stated that his diagnosed of pneumoconiosis was based on the x-ray findings and history of dust exposure. He opined that these conditions resulted in a mild impairment, 60% of which was caused by pneumoconiosis and 40 % by COPD. On his summary form, however, he specifically noted that Claimant's impairment arose wholly from pneumoconiosis, and that Mr. Akers retains the respiratory capacity to perform the work of a coal miner or to perform comparable work in a dust-free environment.

Dr. Glen R. Baker, Jr. examined Claimant on September 28, 2002. (DX 32). Dr. Baker considered the following: symptomatology (daily sputum, cough, shortness of breath aggravated by exertion, and wheezing), employment history (30 years coal mine employment working primarily as a coal loader, quitting in 1987), individual history (sleep apnea, stroke, and prior hospitalization for his lungs with a high fever but he apparently did not have pneumonia), family history (diabetes, cancer, acute myocardial infarction), physical examination (bilateral

[13] Dr. Cohen did not invalidate this study. (CX 4).

[14] Dr. Cohen stated that the exercise portion of this ABG showed an extremely high PO2 of 90 and a PCO2 of 30, which would give him an A-a gradient with exercise of 18 mm/hg, a number usually seen in teenagers and young adults, and certainly incompatible with a 70 year old male who weighs 260 lbs even if he had perfect lungs. (CX 4). Dr. Cohen opined that this test suffers from the same errors that he identified in the October 23, 2002 study.

[15] Dr. Cohen opined that the exercise portion of this ABG was uninterpretable due to the fact that it has a PO2 which is impossibly high, which usually reflects an air bubble in the syringe, or poor calibration of the analyzer. (CX 4). Also, he noted that the A-a gradient on this exam was negative nine mm/hg, which is impossible and clearly indicates lab error. Dr. Byron Westerfield, an internist, pulmonologist, and B-reader, opined that these ABG values do not to meet the disability requirements of § 718.204(b)(2)(ii). (DX 33).

[16] Dr. Cohen's and Dr. Westerfield's reports were offered into evidence as ABG rebuttal. While the parties' briefs rely on the medical conclusions in those reports as support for their respective cases, since those reports were not offered as medical opinions, my consideration of the opinions contained therein is limited to their conclusions concerning study validity.

inspiratory and expiratory wheezes as well as median interstitial type rales on inspiration), smoking history (36 years at less than a pack per day, quitting around age 54), chest x-ray (1/1), PFT (mild obstructive ventilatory defect with no significant post-bronchodilatory improvement), and an ABG (normal). Dr. Baker diagnosed coal worker's pneumoconiosis based on the x-ray and coal dust exposure; chronic obstructive airway disease with mild obstructive defect based on the PFT; chronic bronchitis based on history of symptoms; obstructive sleep apnea based on history. Also, Claimant's FEV 1 was between 60% and 79% of predicted. According to Dr. Baker, this qualifies as a Class 2 impairment based on the Guides to the Evaluation of Permanent Impairment, 5th Edition. He also found that Claimant suffered a second impairment based on Section 5.8, pg. 106 of the guide. He explained that the guide concludes that persons with conditions such as Claimants should limit further exposure to coal dust. Dr. Baker opined that the guide "implies" that Claimant is 100% occupationally disabled. Considering Claimant's exposure to coal dust, Dr. Baker opined that there was no other condition to account for the x-ray findings. As a result, even considering Claimant's long history of smoking, Dr. Baker concluded that any pulmonary impairment would be caused at least in part by coal dust exposure.

Dr. Mann, Claimant's treating physician for 22 years, (Tr. 22-23), submitted a report dated January 6, 2003. (DX 31). Dr. Mann considered the following: symptomatology (pulmonary difficulties dating back to 1979, including chest pain and breathing problems; presently Mr. Akers complains of wheezing, cough, dyspnea on exertion, shortness of breath, chronic sputum production, and a progressively deteriorating orthopneic pattern and endurance for work), employment history (worked in the mining industry for years, quitting in 1987), individual history (documented chronic pneumoconiosis secondary to coal dust exposure), smoking history (tobacco exposure/abuse), physical examination (Claimant is obese, the thorax examination reveals a barrel chest with decreased breath sounds and bilateral inspiratory and expiratory wheezing with a protracted expiratory phase), chest x-ray (read as positive[17]), PFT (the 9/28/02 post-bronchodilator study show a mild restrictive component), and an ABG (9/28/02 study). Dr. Mann diagnosed CWP; mild restrictive lung disease on the basis of pneumoconiosis; chronic airway disease and small airway disease on the basis of tobacco exposure; chronic pulmonary infections from pneumoconiosis; chronic bronchitis; sleep apnea; and obesity. He opined that Claimant's breathing impairment and disability were due to coal dust exposure from years in the mining industry. Dr. Mann explained that the chronic obstructive component of Claimant's pulmonary disease was partially related to tobacco abuse, but it was mainly related to chronic bronchitis due to pneumoconiosis. He further opined that Claimant is totally disabled from employment, and 100% disabled from the mining industry on the basis of pneumoconiosis. This restriction is based on a requirement that he avoid further dust exposure and exertional activities due to his restricted respiratory capacity.

Dr. Bruce Broudy, an internist, pulmonologist, and B-reader, performed a medical evidence review, and submitted a report dated August 15, 2003. (EX 1). Dr. Broudy considered the following: Dr. Baker's September 28, 2002 medical report; Dr. Mann's January 6, 2003 medical report; Dr. Ahmed's interpretations of the February 22, 2002 and June 26, 2002 x-rays;

[17] Unlike the PFT and ABG studies he considered, it is not possible from description to definitively determine the specific x-ray interpretation Dr. Mann considered. I am, however, sufficiently confident that Dr. Mann was discussing the September 28, 2002 x-ray evidence, and the record does include two interpretations of that film.

Dr. Halbert's interpretations of the June 26, 2002, August 29, 1997, and May 1, 1997[18] x-rays; and Dr. Hussain's interpretation of the June 26, 2002 x-ray. Based on Dr. Halbert's B-readings Dr. Broudy opined that his interpretations should take precedence over the others, and thus, Claimant "probably" does not have CWP. Dr. Broudy next determined that there is no evidence that Claimant has a disabling respiratory impairment because both the PFT and ABG studies exceed the minimum federal criteria for disability in coal miners. Based on the September 28, 2002 PFT, Dr, Broudy added that Claimant has non-disabling mild obstructive airways disease which is "probably due to cigarette smoking."

Dr. Broudy was deposed by the Employer on September 5, 2001, when he repeated the findings of his earlier written report (EX 1). Concerning his weighing of the x-ray interpretations, Dr. Broudy noted that Dr. Halbert was a B-reader, and Drs. Hussain, Ahmed, and Baker do not have comparable experience or expertise, noting that Dr. Baker reads just about everything positive, and that he knows Dr. Halbert well and knows he has been reading for many years.

Smoking History

At the hearing, Claimant testified that he had smoked from age 17 to 55, or 38 years, at a rate of 1 to 1 ½ packs per day. (Tr. 24). Thus, Claimant testified to a smoking history of 38 to 57 pack-years. Dr. Hussain reported a smoking history of 40 years at one pack per day, ending in 1987. (DX 11). Dr. Baker reported a smoking history of less than a pack per day for 36 years, quitting around age 54. (DX 32).

I presume that the Claimant would not purposely overstate his smoking history, thereby presenting a possible detriment to his own case. As a result, I find Claimant's testimony to be the most probative. Therefore, since I find that Claimant smoked for 38 years at a rate of 1 to 1 ½ packs per day, I would credit him with 1 ¼ packs per day, or at least 47 ½ pack-years. I also find that he quit smoking in approximately 1987.

DISCUSSION AND APPLICABLE LAW

Mr. Akers' claim was filed after March 31, 1980, the effective date of Part 718, and must therefore be adjudicated under those regulations. To establish entitlement to benefits under Part 718, Claimant must establish, by a preponderance of the evidence, that he:

1. Is a miner as defined in this section; and

2. Has met the requirements for entitlement to benefits by establishing that he:

   (i) Has pneumoconiosis (see § 718.202), and

   (ii) The pneumoconiosis arose out of coal mine employment (see § 718.203), and

   (iii) Is totally disabled (see § 718.204(c)), and

[18] The admitted record does not include a May 1,1997 x-ray interpretation by Dr. Halbert.

(iv) The pneumoconiosis contributes to the total disability (see § 718.204(c)); and

3. Has filed a claim for benefits in accordance with the provisions of this part.

Section 725.202(d)(1-3); *see also* §§ 718.202, 718.203, and 718.204(c).

Pneumoconiosis

In establishing entitlement to benefits, Claimant must initially prove the existence of pneumoconiosis under § 718.202. Claimant has the burden of proving the existence of pneumoconiosis, as well as every element of entitlement, by a preponderance of the evidence. *See Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994). Pneumoconiosis is defined by the regulations:

> (a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical" pneumoconiosis and statutory, or "legal" pneumoconiosis.
>
> (1) *Clinical Pneumoconiosis*. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, i.e., conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
>
> (2) *Legal Pneumoconiosis*. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
>
> (b) For the purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.
>
> (c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

Sections 718.201(a-c).

Section 718.202(a) sets forth four methods for determining the existence of pneumoconiosis.

(1) Under § 718.202(a)(1), a finding that pneumoconiosis exists may be based upon x-ray evidence. Because pneumoconiosis is a progressive disease, I may properly accord greater weight to the interpretations of the most recent x-rays, especially where a significant amount of time separates the newer from the older x-rays. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (en banc); *Casella v. Kaiser Steel Corp.*, 9 B.L.R. 1-131 (1986). I may also assign heightened weight to the interpretations by physicians with superior radiological qualifications. *See McMath v. Director, OWCP*, 12 B.L.R. 1-6 (1988); *Clark*, 12 B.L.R. 1-149 (1989).

The record includes nine interpretations of five chest x-rays, and one quality-only interpretation. Dr. Halbert, a radiologist and B-reader, read the August 29, 1997 film as negative for pneumoconiosis. There were no positive readings. Therefore, I find that the August 29, 1997 film is negative for pneumoconiosis.

Dr. Fino, a B-reader, read the February 22, 2002 chest x-ray as negative for pneumoconiosis. On the other hand, Dr. Ahmed, a radiologist and B-reader, interpreted the film as positive. I accord greater weight to the positive reading by Dr. Ahmed than I do the negative interpretation by Dr. Fino based on Dr. Ahmed's superior credentials. Therefore, I find that the February 22, 2002 film is positive for pneumoconiosis.

Drs. Ahmed and Hussain interpreted the June 26, 2002 chest x-ray as positive for pneumoconiosis, but Dr. Halbert read the same film as negative. As Drs. Ahmed and Halbert are both dually credentialed in x-ray interpretation, I find that their opinions are balanced. Thus, I find that the June 26, 2002 film is inconclusive for the existence of pneumoconiosis.

Dr. Baker, a B-reader, read the September 28, 2002 film as positive for pneumoconiosis. Dr. Halbert interpreted the film as 1/1 st, but noted that while the film demonstrated findings which are seen in some types of pneumoconiosis, he also emphasized that these findings were not consistent with those seen in CWP. Based solely on ILO Classification, both of these films would be positive for pneumoconiosis. Considering Dr. Halbert's comments, however, I find that reliance solely on the ILO Classification would undermine the true nature of his interpretation. In addition, I accord more weight to the dually qualified reading by Dr. Halbert than I do Dr. Baker's B-reading. Therefore, I find that the September 28, 2002 chest x-ray is negative for pneumoconiosis.

Dr. Cappiello, a radiologist and B-reader, interpreted the December 27, 2004 film as positive for pneumoconiosis. There were no negative readings. Therefore, I find the December 27, 2004 film to be positive for pneumoconiosis.

I have found two of the chest x-rays of record to be positive, two to be negative, and one to be inconclusive. In addition, I find those readings by dually credentialed physicians are evenly balanced, with three positive and three negative interpretations. Also, I accord less weight to the 1997 film due to its remoteness. On the other hand, since the 2004 film is over two years more recent than the next most recent film, and since I find two years to be a significant amount of time when considering the progressive nature of the disease, I find the December 27, 2004 chest x-ray to be the most probative. Therefore, based on the highly credentialed

interpretation by Dr. Cappiello, I find that the preponderance of the evidence under subsection (a)(4) is positive for pneumoconiosis

(2) Under § 718.202(a)(2), a determination that pneumoconiosis is present may be based, in the case of a living miner, upon biopsy evidence. The evidentiary record does not contain any biopsy evidence. Therefore, I find that the Claimant has failed to establish the existence of pneumoconiosis through biopsy evidence under subsection (a)(2).

(3) Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of several cited presumptions are found to be applicable. In this case, the presumption of § 718.304 does not apply because there is no evidence in the record of complicated pneumoconiosis. Section 718.305 is not applicable to claims filed after January 1, 1982. Finally, the presumption of § 718.306 is applicable only in a survivor's claim filed prior to June 30, 1982. Therefore, Claimant cannot establish pneumoconiosis under subsection (a)(3).

(4) The fourth and final way in which it is possible to establish the existence of pneumoconiosis under § 718.202 is set forth in subsection (a)(4) which provides in pertinent part:

> A determination of the existence of pneumoconiosis may also be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

§ 718.202(a)(4).

This section requires a weighing of all relevant medical evidence to ascertain whether or not the claimant has established the presence of pneumoconiosis by a preponderance of the evidence. Any finding of pneumoconiosis under § 718.202(a)(4) must be based upon objective medical evidence and also be supported by a reasoned medical opinion. A reasoned opinion is one which contains underlying documentation adequate to support the physician's conclusions. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts, and other data on which he bases his diagnosis. *Oggero v. Director, OWCP*, 7 B.L.R. 1-860 (1985). A brief and conclusory medical report which lacks supporting evidence may be discredited. *See Lucostic v. United States Steel Corp.*, 8 B.L.R. 1-46 (1985); *see also*, *Mosely v. Peabody Coal Co,.* 769 F.2d 257 (6th Cir. 1985). Further, a medical report may be rejected as unreasonable where the physician fails to explain how his findings support his diagnosis. *See Oggero*, 7 B.L.R. 1-860.

Dr. Hussain considered employment and smoking history, physical examination results, a normal, non-qualifying ABG, an a non-qualifying PFT in which he noted poor effort. While Dr. Hussain initially noted that Claimant suffers from both pneumoconiosis and COPD, without identifying which objective values he relied on to reach this conclusion, in another portion of his

report, he specifically stated that he diagnosed pneumoconiosis based on the x-ray and history of coal dust exposure. *Cornett v. Benham Coal, Inc*., 227 F.3d 569 (6th Cir. 2000)(merely restating an x-ray is not a reasoned medical judgment under § 718.202(a)(4)). Next, Dr. Hussain failed to explain how the non-qualifying PFT with poor cooperation and understanding, and a non-qualifying ABG supported his diagnosis of COPD. *Duke v. Director, OWCP*, 6 B.L.R. 1-673 (1983)(a report is properly discredited where the physician does not explain how underlying documentation supports his or her diagnosis); *Houchin v. Old Ben Coal Co.*, 6 B.L.R. 1-1141 (1984)(little or no weight may be accorded to a ventilatory study where the miner exhibited "poor" cooperation or comprehension); *Goss v. Eastern Assoc. Coal Corp.*, 7 B.L.R. 1-400 (1984)(a report which is seriously flawed may be discredited). Also, Dr. Hussain failed to explain why Claimant's condition was not wholly attributable to cigarette smoking. *Duke*, 6 B.L.R. 1-673. Based on these factors, I find that Dr. Hussain's pneumoconiosis diagnosis does not constitute a reasoned opinion for determining the existence of pneumoconiosis under subsection (a)(4). In addition, while his report explicitly states that he diagnosed only clinical pneumoconiosis, I further find that even if Dr. Hussain had intended to attribute Claimant's COPD to coal dust exposure, I would still find his report unreasoned for the reasons stated. Therefore, I accord Dr. Hussain's opinion no weight for the purpose of determining whether Claimant suffers from pneumoconiosis under subsection (a)(4).

Dr. Baker examined Claimant, and based on an x-ray and exposure he diagnosed pneumoconiosis; based on the PFT results, he diagnosed mild obstructive ventilatory defect with no significant post-bronchodilatory improvement; and based on history, he diagnosed chronic bronchitis. While Dr. Baker set forth clinical observations and findings, I find his reasoning is not supported by adequate data. First, the PFT he relied upon was non-qualifying under Department of Labor standards, and his general statement, "any pulmonary impairment would be caused at least in part by coal dust exposure," is unsupported. *Smith v. Eastern Coal Co*., 6 B.L.R. 1-1130 Second, concerning chronic bronchitis, an analysis of history of symptoms is not objective. Third, Dr. Baker based his diagnosis solely on an x-ray and history of dust exposure. *Cornett*, 227 F.3d 569. As a result, I find that Dr. Baker's opinion does not constitute a reasoned medical opinion for the purposes of diagnosing pneumoconiosis under subsection (a)(4). Therefore, I accord his clinical pneumoconiosis diagnosis no weight under subsection (a)(4), and give his legal pneumoconiosis diagnosis little weight.

Dr. Mann considered employment history, smoking history, and the September 28, 2002 PFT, ABG, and x-ray interpretation. Based on this evidence, Dr. Mann diagnosed CWP; mild restrictive lung disease on the basis of pneumoconiosis; chronic airway disease and small airway disease on the basis of tobacco exposure; chronic pulmonary infections from pneumoconiosis; chronic bronchitis; sleep apnea; and obesity. He opined that Claimant's breathing impairment and disability were due to coal dust exposure from years in the mining industry. Dr. Mann explained that the chronic obstructive component of Claimant's pulmonary disease was partially related to tobacco abuse, but it was mainly related to chronic bronchitis due to pneumoconiosis. Dr. Mann, however, failed to explain why Claimant's mild restrictive lung disease, chronic obstructive airway disease, small airway disease, and chronic bronchitis were mainly the result of coal dust exposure, and not wholly attributable to Claimant's 45 ½ pack-year smoking history. *Duke*, 6 B.L.R. 1-673. As a result, while Dr. Mann's opinion is sufficiently documented, I find it to be insufficiently reasoned due to his failure to support his legal pneumoconiosis conclusion.

Therefore, despite his status as Claimant's treating physician for 22 years, I accord Dr. Mann's opinion little weight.

Based on a medical evidence review, Dr. Broudy opined that Claimant did not suffer from either clinical or legal pneumoconiosis. Concerning clinical pneumoconiosis, Dr. Broudy prioritized the readings of Dr. Halbert over those of Drs. Hussain, Baker, and Ahmed, noting Dr. Halbert's advanced experience and expertise. As discussed in the analysis under subsection (a)(1), while Dr. Halbert is both a radiologist and B-reader, the record demonstrates that Dr. Ahmed is equally credentialed. Furthermore, I do not find Dr. Broudy's knowledge of Dr. Halbert and the length of time Dr. Halbert has been reading x-rays to be a sufficient justification for weighting Dr. Halbert's opinions over those of Dr. Ahmed. Next, Dr. Broudy's clinical pneumoconiosis conclusion stated that Claimant "probably" does not have CWP. An opinion may be given little weight if it is equivocal or vague. *Griffith v. Director, OWCP*, 49 F.3d 184 (6th Cir. 1995) (treating physician's opinion entitled to little weight where he concluded that the miner "probably" had black lung disease). Therefore, based on Dr. Broudy's unsupported exclusion of Dr. Ahmed's x-ray interpretations, and the equivocal nature of his clinical pneumoconiosis conclusion, I find that his report is insufficiently reasoned, and accord it little weight. Furthermore, I also find Dr. Broudy's legal pneumoconiosis analysis to be unsupported and unreasoned. He equivocally stated that Claimant's mild obstructive airways disease was "probably due to cigarette smoking," and he failed to explain why he excluded coal dust exposure as a cause of this condition. Thus, I accord Dr. Broudy's legal pneumoconiosis analysis little weight.

The evidentiary record contains four poorly reasoned narrative medical opinions. Therefore, I find that Claimant has failed to prove the existence of pneumoconiosis by a preponderance of the evidence under subsection (a)(4). But since he has established the presence of pneumoconiosis under subsection (a)(1), I find that Claimant has established pneumoconiosis under §718.202 (a),

Arising out of Coal Mine Employment

In order to be eligible for benefits under the Act, Claimant must also prove that pneumoconiosis arose, at least in part, out of his coal mine employment. § 718.203(a). For a miner who suffers from pneumoconiosis and was employed for ten or more years in one or more coal mines, it is presumed that his pneumoconiosis arose out of his coal mine employment. *Id.* As I have found that Claimant has established at least 20 years of coal mine employment, and as no rebuttal evidence was presented, I find that Claimant's pneumoconiosis arose out of his coal mine employment in accordance with the rebuttable presumption set forth in § 718.203(b).

Total Disability

To be entitled to benefits under the Act, Claimant must also demonstrate that he is totally disabled from performing his usual coal mine work or comparable work due to pneumoconiosis under one of the five standards of § 718.204(b) or the irrebuttable presumption referred to in § 718.204(b). The Board has held that under Section 718.204(b), all relevant probative evidence, both like and unlike must be weighed together, regardless of the category or type, in the

determination of whether the Claimant is totally disabled. *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195 (1986); *Rafferty v. Jones & Laughlin Steel Corp.*, 9 B.L.R. 1-231 (1987). Claimant must establish this element of entitlement by a preponderance of the evidence. *Gee v. W.G. Moore & Sons*, 9 B.L.R. 1-4 (1986).

I have determined that Claimant has not established that he suffers from complicated pneumoconiosis. Therefore, the irrebuttable presumption of § 718.304 does not apply.

Total disability can be shown under § 718.204(b)(2)(i) if the results of pulmonary function studies are equal to or below the values listed in the regulatory tables found at Appendix B to Part 718. None of the PFT values of record produced values equal to or below those found in Appendix B of Part 718. Therefore, I find that Claimant has failed to establish total disability under subsection (b)(2)(i).

Total disability can be demonstrated under § 718.204(b)(2)(ii) if the results of arterial blood gas studies meet the requirements listed in the tables found at Appendix C to Part 718. None of the ABG studies of record produced qualifying values. Therefore, I find that Claimant has failed established that he is totally disabled under subsection (b)(2)(ii).

Total disability may also be shown under § 718.204(b)(2)(iii) if the medical evidence indicates that Claimant suffers from cor pulmonale with right-sided congestive heart failure. The record does not contain any evidence indicating that Claimant suffers from cor pulmonale with right-sided congestive heart failure. Therefore, I find that Claimant has failed to establish the existence of total disability under subsection (b)(2)(iii).

Section 718.204(b)(2)(iv) provides for a finding of total disability if a physician, exercising reasoned medical judgment based on medically acceptable clinical or laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevented the miner from engaging in his usual coal mine employment or comparable gainful employment.

In assessing total disability, the administrative law judge is required to compare the exertional requirements of the claimant's usual coal mine employment with a physician's assessment of the claimant's respiratory impairment. *Cornett v. Benham Coal, Inc.*, 227 F.3d 569 (6th Cir. 2000). Once it is demonstrated that the miner is unable to perform his usual coal mine work, a *prima facie* finding of total disability is made and the party opposing entitlement bears the burden of going forth with evidence to demonstrate that the miner is able to perform "comparable and gainful work" pursuant to § 718.204(b)(1). *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988). Nonrespiratory and nonpulmonary impairments have no bearing on establishing total disability due to pneumoconiosis. § 718.204(a); *Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241 (1994). All evidence relevant to the question of total disability due to pneumoconiosis is to be weighed, with the claimant bearing the burden of establishing by a preponderance of the evidence the existence of this element. *Mazgaj v. Valley Camp Coal Co.*, 9 B.L.R. 1-201 (1986). Claimant's usual coal mine employment involved sitting for six hours per day, standing for four hours per day, lifting and carrying up to 25 lbs, and strenuous climbing. (DX 4; Tr. 15-16, 20).

Dr. Hussain determined that the non-qualifying ABG values he considered were normal.[19] In addition, while he recorded poor cooperation and understanding on the PFT he performed, I note that the resultant values were non-qualifying. In *Crapp v. U.S. Steel Corp.*, 6 B.L.R. 1-476, 479 (1983), the Board held that a non-conforming pulmonary function study may be entitled to probative value where the results exceed the table values, because had the claimant understood or cooperated more fully, the test results could only have been higher. Dr. Hussain also performed a physical examination, and considering prior coal mine employment history, he concluded that Claimant was not totally disabled. I find that his opinion is based on the objective evidence before him, and is thus, well-reasoned and well-documented. Therefore, I find that Dr. Hussain's total disability opinion is entitled to probative weight.

Dr. Baker based his diagnosis on an x-ray, normal ABG, a non-qualifying PFT, and Claimant's reported history of symptoms. Dr. Baker stated that considering the PFT values, Claimant was 100 % occupationally disabled. He based this determination on his finding that Claimant has a Class 2 impairment as classified in the Guide to Evaluation of Permanent Impairment, 5th Edition.[20] According to Dr. Baker, the guide concludes that persons with pneumoconiosis should limit further exposure to coal dust, and that this conclusion "implies" that the Miner is 100% disabled from returning to coal mine employment or similar dusty occupations. His rational is that the Claimant should not return to a dusty environment so as not to exacerbate his pneumoconiosis. An opinion of the inadvisability of returning to coal mine employment because of pneumoconiosis is not the equivalent of a finding of total disability. *Zimmerman v. Director, OWCP*, 871 F.2d 564, 567 (6th Cir. 1989); *Taylor v. Evans & Gambrel Co.,* 12 B.L.R. 1-83 (1988); *Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91 (1988); *Bentley v. Director, OWCP*, 7 B.L.R. 1-612 (1984); *Brusetto v. Kaiser Steel Corp.,* 7 B.L.R. 1-422 (1984). Therefore, Dr. Baker has not accurately addressed whether Claimant's condition prevents him from engaging in his usual coal mine employment or comparable gainful employment under standards mandated by the present Act, but instead has simply recommended that Claimant not engage in these activities. Also, his documentation of limitations on Claimant's residual exertional capacity necessary to perform his duties as a coal miner is virtually non-existent. As a result, I find that Dr. Baker's total disability conclusion does not constitute a reasoned and documented medical opinion. Therefore, I accord his opinion little weight.

Dr. Mann determined that Claimant was totally disabled from performing any employment. He based his opinion on a physical examination, and non-qualifying ABG and PFT studies, but failed to explain how these non-qualifying values equate to total disability. Also, Dr. Mann specifically noted that Claimant's restrictive respiratory capacity as justification for his total disability conclusion, but he did not explain how this "mild restrictive lung disease" rose to the level of 100% disabling. In addition, I find Dr. Mann's analysis of Claimant's inability to perform any employment to be poorly document due to his failure to provide more

[19] While Dr. Cohen, an internist and pulmonologist, invalidated the post-exercise portion of Dr. Hussain's ABG study, he did not disturb the pre-exercise portion of this test. I find that while qualifying post-exercise values might have changed Dr. Hussain's ultimate disability conclusion, the fact still remains that he considered the valid pre-exercise values not to constitute grounds for finding Claimant unable to perform his previous job duties from a pulmonary standpoint.

[20] Mere designation of a Claimant's pulmonary impairment as a Class I or II impairment does not warrant a finding of total disability under the Act absent a well-reasoned and well-documented opinion that the standards of the Act have been met.

than a general explanation of Claimant's usual coal mine employment. Based on these factors, I find Dr. Mann's total disability analysis not to be well-reasoned or documented. Therefore, despite his status as Claimant's treating physician, I accord his opinion little weight.

Dr. Broudy opined that Claimant's mild obstructive airways disease was not disabling. He based his opinion on the non-qualifying September 28, 2002 PFT and ABG studies. Supported by the objective evidence before him, I find that Dr. Broudy's opinion concerning total disability is well-reasoned and well-documented. Therefore, bolstered by his credentials as an internist and pulmonologist, I accord his opinion probative weight.

I have determined that Dr. Broudy's and Dr. Hussain's total disability conclusions are well-reasoned and well-documented, and thus, accorded them probative weight. I have also found Dr. Mann's and Dr. Baker's conclusions to be entitled to little weight. Therefore, I find that Claimant has failed to prove by a preponderance of the evidence that he is totally disabled under § 718.204(b)(iv).

Claimant has failed to establish that he is totally disabled under subsections (b)(i)-(iv). Upon consideration of all evidence concerning total disability under §718.204 (b), therefore, I find that Claimant has failed to established that he is totally disabled from a pulmonary or respiratory standpoint under §718.204(b).

Complete Pulmonary Evaluation

The District Director is required to provide each miner applying for benefits with the "opportunity to undergo a complete pulmonary evaluation at no expense to the miner." §725.406(a). A complete evaluation includes a report of the physical examination, a chest x-ray, a pulmonary function study, and an arterial blood gas study. Reviewing courts have added to this burden by requiring the pulmonary evaluation be sufficient to constitute an opportunity to substantiate a claim for benefits. *See Petry v. Director*, OWCP 14 B.L.R. 1-98, 1-100 (1990)(en banc); *see also Newman v. Director*, OWCP, 745 F.2d 1161 (8th Cir. 1984); *Prokes v. Mathews*, 559 F.2d 1057, 1063 (6th Cir. 1977).

Due to the deficiencies in Dr. Hussain's pneumoconiosis analysis, I found that his medical opinion was insufficient to constitute an opportunity to substantiate Mr. Akers' claim. Dr. Hussain's total disability analysis, however, was found to be reasoned and documented, and provided a sufficient basis to deny this claim. *Jeffrey v. Mingo Logan Coal Co*., No. 05-0107 BLA (BRB, Sept. 22, 2005)(*unpub.*)(due to the fact that the administrative law judge relied, in part, on the DOL sponsored examination to find that the claimant was not totally disabled, the Board did not remand the claim for a complete pulmonary evaluation despite the physician's unreasoned opinion concerning pneumoconiosis). As a result, even if this claim were remanded to the Director to provide a reasoned and documented opinion concerning the existence of pneumoconiosis, Claimant could not prevail. Therefore, I find that remand of this case would be futile. *Larioni v. Director, OWCP*, 6 BLR 1-1276 (1984).

Entitlement

The Claimant, Mr. Akers, has shown by a preponderance of the evidence that he suffers from pneumoconiosis arising out of coal mine employment, but he has failed to prove that he is totally disabled due to pneumoconiosis. Therefore, Mr. Akers is not entitled to benefits under the Act.

Attorney's Fees

An award of attorney's fees is permitted only in cases in which the claimant is found to be entitled to benefits under the Act. Because benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for the representation and services rendered in pursuit of the claim.

ORDER

IT IS ORDERED that the claim of Carmel Akers for benefits under the Act is hereby DENIED.

A

THOMAS F. PHALEN, JR.
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Donald S. Shire, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).